

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=63-019235

STATE FILE NUMBER

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No. 43Primary Registration District No. 3007Registrar's No. 1575**FILED JUN 3 1963**

1. PLACE OF DEATH a. COUNTY Butler		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Butler	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR Poplar Bluff		c. CITY OR TOWN Poplar Bluff	
Length of stay in 1b 5 Days		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION VA. Hospital		d. STREET ADDRESS (If outside, give location) 816 Oak Hill Road	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print)		First CHARLES E. Middle FRANKLIN Last GLOVER		4. DATE OF DEATH Month May Day 18 Year 1963	
5. SEX Male	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 5-17-07	9. AGE (last birthday) 56	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tool Dresser		10b. KIND OF BUSINESS OR INDUSTRY Tool Dresser		11. BIRTHPLACE (City and state or country) Dexter, Mo.	
12. CITIZEN OF WHAT COUNTRY U.S.A.		13a. FATHER'S NAME Thomas Glover		13b. MOTHER'S MAIDEN NAME Ella Maynard	
14. NAME OF HUSBAND OR WIFE None		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of) Yes WW2		16. SOCIAL SECURITY NO. VA. Hospital Records, Poplar Bluff, Mo.	
17. INFORMANT VA. Hospital Records, Poplar Bluff, Mo.		Address			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) LEFT LUNG PNEUMONIA		INTERVAL BETWEEN ONSET AND DEATH 3 Days
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) SEVERE PULMONARY EMPHYSEMA		8 Years
DUE TO (c) SEVERE MALNUTRITION		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown

19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of Item 18.)	
20c. TIME OF INJURY Hour 1:20 a.m. Month 5 Day 18 Year 63		20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
20f. CITY, TOWN, OR LOCATION Poplar Bluff, Mo.		COUNTY Butler		STATE Missouri	
21. VA attended the deceased from 5-13-63 to 5-18-63 Death occurred at 1:20 a.m. on the date stated above, and to the best of my knowledge, from the causes stated.		22a. SIGNATURE Robert S. Cohen (Degree or title) ROBERT S. COHEN M.D. Chief Med. Svc.		22b. ADDRESS VA Hospital Poplar Bluff, Mo.	
22c. DATE SIGNED 5-20-63		23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 5-20-1963	
23c. NAME OF CEMETERY OR CREMATORY City Cemetery		23d. LOCATION (City, town, or county) Poplar Bluff, Mo.		(State)	
24. FUNERAL DIRECTOR Greer Croy & Fitch Poplar Bluff, Mo.		ADDRESS 5-27-1963		25. DATE RECD. BY LOCAL REG.	
26. REGISTRAR'S SIGNATURE Robert S. Cohen					

(Licensed Embalmer's Statement on Reverse Side)

USE BLACK INK
OR
TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

DATE AMENDED

VS 300
Rev. 4/591012820128234 05 067 08 29 527.1101112 5-013 1-0

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,

or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____

Signature of Student Embalmer

Signed _____

Philip J. Cassidy

Licensed Embalmer No. *4618*

P.O. Address *Caplan Bluff, Mo.*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.